

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2352AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2009
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF WINNEMUCCA		STREET ADDRESS, CITY, STATE, ZIP CODE 1250 HANSEN ST WINNEMUCCA, NV 89445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted in your facility on 6/8/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was ten. Ten resident files were reviewed and six employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. Complaint #21769 was substantiated without citations due to the actions of the facility. The following deficiencies were identified:	Y 000		
Y 444 SS=F	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by:	Y 444		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 444	Continued From page 1 Based on record review on 6/8/09, the facility did not ensure 9 of 19 smoke detectors were tested 12 out of the past 12 months (May, 2008 to May, 2009). Severity: 2 Scope: 3	Y 444			
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 6/8/09, the facility failed to ensure that 1 of 10 residents received medications as prescribed (Resident #3). Severity: 2 Scope: 1	Y 878			

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